DPHHS-QAD/CCL-20A
(Revision 6-06)

OFFICE USE
CAPS# _____
PS# _____

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
For Registered and Licensed Child Care Providers
Criminal / Protective Service / Motor Vehicle
Background Checks

PERSONAL INFORMATION

Section A – Current Information

Phone # _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: [ ] Male [ ] Female Date of Birth: _____ Social Security #_____

Section B – Past Residences

Within the last five (5) years, have you…

1. …lived in another state? [ ] Yes [ ] No
2. …lived on or do you now live in an area designated as an Indian reservation? [ ] Yes [ ] No

If you answered yes to the any of the above questions:

- Please state where you have lived in the table below.
- You will need to obtain an out of state background check or a tribal background check at your cost.

City	County	Reservation	State	Dates of Residency (From – To)

Section C – Prior Caregiver Approvals

Have you been… …registered / licensed to care for children before? [ ] Yes [ ] No
…approved, in any capacity, to provide care in a child care facility? [ ] Yes [ ] No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

_____
(Director / Facility Name) (Dates)

_____
(Director / Facility Name) (Dates)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FACILITY INFORMATION

Section D – Employment Status

The facility that I am working / living at is: Provider #: _____

Director Name / Facility Name: _____

Facility Mailing Address :_____
(City) (State) (Zip)

My ROLE with this facility is (please check all that apply):

Center Use Only:

- ☐ Director
- ☐ Primary Caregiver
- ☐ Aide
- ☐ Substitute Provider
- ☐ Volunteer
- ☐ Non-Provider Staff

Family and Group Only:

- ☐ Director
- ☐ Primary Caregiver
- ☐ Caregiver
- ☐ Non-Provider Staff
- ☐ Substitute Provider
- ☐ Spouse
- ☐ Adult Child
- ☐ Other Adult
- ☐ Volunteer

My* START DATE *at this facility is: _____

Section E – Authorization Statement

I hereby authorize any law enforcement, protective services, or motor vehicle agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services at the addresses below or any related field office:

Quality Assurance Division - Licensure Bureau - Child Care Licensing
2401 Colonial Dr / PO Box 202953 / Helena MT 59620

Child Care Licensing
848 Main #20 / Billings MT 59105

I understand that any information obtained from these checks can be used by the Department to evaluate my application for registration or licensure. I hereby authorize release of such information to any registered or licensed child care facility in the State of Montana employing me or considering my application for employment. A copy of this form is as valid as the original. This release is valid only at the facility listed in Section D. It is valid for a period of at least one year. It may be valid for up to 3 years depending on the facility's license/registration status.

NOTE: Any deletions or oversights may result in the denial of your application.

Section F – Authorization Signature

Signed: _____ Date: _____

(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

_____
Notary Public for the State of Montana

Residing at: _____

My commission expires: _____